Executive summary

The Congress charges the Medicare Payment Advisory Commission with reviewing Medicare payment policies and making recommendations concerning them each March. The Commission's goal is for Medicare payments to cover the costs efficient providers incur in furnishing quality care to beneficiaries. If payments are set too low, providers will not want to participate in the program and Medicare beneficiaries may not continue to have access to high-quality care. If payments are set too high, taxpayers and beneficiaries will bear too large a burden.

In this report, we review Medicare prospective payment systems (PPSs) for seven sectors: hospital inpatient, hospital outpatient, physician, skilled nursing, home health, outpatient dialysis, and ambulatory surgical center. We also discuss payment and eligibility policy for the Medicare+Choice (M+C) program and two broader Medicare payment issues:

- the growth in Medicare spending, both as a share of the Federal budget and gross domestic product, and
- the quality of care Medicare beneficiaries receive.

The Commission seeks to improve the quality of care Medicare beneficiaries receive. In this report, in addition to reporting on the quality of care beneficiaries receive, the Commission recommends building incentives into Medicare payment systems to reward high and improved quality. Beginning in 2005, we recommend paying for quality in two sectors where there is consensus on measures and they are regularly collected—outpatient dialysis and the M+C program. We anticipate expanding payment for quality to other sectors in the future as better measures become available.

At the beginning of each chapter we list the recommendations contained in it. Within the chapters we present each recommendation, its rationale, and its implications for beneficiaries, providers, and spending. The spending implications are presented as ranges over one- and five-year periods and unlike official budget estimates, do not take into account the complete package of policy recommendations, the interactions among them, or assumptions about changes in provider behavior. In Appendix A, we present a list of all recommendations and the Commissioners' votes.

Context

In December 2003, the Congress enacted a major Medicare reform bill, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA). In addition to establishing a prescription drug benefit in 2006, the MMA also makes changes affecting many of the payment systems discussed in this report. We note the features of the law that are most relevant to our discussion of each payment system. The full ramifications of the changes will take time to become evident and, in the meantime, add uncertainty to some of our estimates. In future reports the Commission will more fully consider specific aspects of the MMA.

In Chapter 1, we establish a financial context for evaluating the payment updates recommended in subsequent chapters. Even before adding in the costs of the MMA, we find that Medicare spending is likely to put increasing fiscal pressure on the federal budget, requiring policymakers to make increasingly difficult trade-offs between Medicare spending and other budget priorities. We also find that even though beneficiaries are still reporting good access to care, many beneficiaries pay large amounts out of pocket for health care and some have few options to obtain comprehensive supplemental insurance coverage for services not covered by Medicare.

Quality of care provided to Medicare beneficiaries

Ensuring that Medicare beneficiaries have access to high-quality care is a key objective of the Medicare program. Although CMS is working to improve quality, current payment systems are largely neutral or negative toward quality. It is crucial for the Medicare program to build incentives for improving quality into the payment systems.

To help target quality improvement initiatives, in Chapter 2 we analyze the quality of care in hospitals, ambulatory settings, and M+C plans using a range of available indicators. The hospital and ambulatory settings affect a large number of beneficiaries and thus quality in those settings is critical to the program. We find quality varies based on the indicators used. Hospital mortality rates are improving while at the same time, many beneficiaries experience adverse events in hospitals. Beneficiaries are being admitted to hospitals for conditions that might have been prevented in ambulatory settings, and although improving, gaps exist between care delivered and

optimum care. Yet surveys show that overall, beneficiaries rate their providers highly. These data raise questions for further research, but may also point to where payment incentives are most needed.

Assessing payment adequacy and updating payments in fee-for-service Medicare

In Chapter 3, we make payment update and other recommendations for fee-for-service Medicare. We use a two-part framework to help us develop our update recommendations. In part one, we assess the adequacy of Medicare payments for efficient providers in 2004 considering market factors, such as access to care and quality, and the relationship between payments and providers' costs. We assess payment adequacy in aggregate for all providers in each sector, taking into account policy changes scheduled to take effect under current law. In part two, we assess whether and how payments should change in 2005 considering changes in input prices, our expectation for productivity gains, and where applicable, an allowance for cost-increasing and quality-enhancing technology. A target for productivity improvement is essential to encourage providers to be more efficient and to assure that taxpayers share in savings from improvements in productivity when they occur.

Hospital inpatient and outpatient services

Our assessment of beneficiaries' access to care, volume of services, access to capital, quality, and the relationship of current Medicare payments to costs indicates that payments are adequate to cover the costs of furnishing hospital care to beneficiaries. However, there is considerable uncertainty over future trends in both cost growth and Medicare payments and the Commission is concerned about the drop in overall Medicare margins for hospitals over a relatively short period of time. Whether the rapid increase in hospitals' per unit costs has reached its peak, and how payments will change as CMS's new outlier policy and the MMA policy changes take effect are both open questions. This uncertainty argues for caution in this year's update. The Commission finds the most prudent course for this year is for the Congress to raise inpatient and outpatient payment rates by the full projected increase in the hospital market basket index.

The Commission also recommends that the Congress eliminate outlier payments in the outpatient payment system and return them to the base payment. Our analysis finds that outlier payments are predominately for low-cost outpatient services that pose little financial risk to hospitals. In addition, the outlier payment mechanism is vulnerable to gaming. We conclude that outpatient outlier payments are not needed to protect hospitals from financial risk.

Physician services

To assess Medicare's payment adequacy for physician services, we consider four market factors and find that these indicators are generally positive or neutral. Access to physician care continues to be good overall and the number of physicians billing Medicare is increasing in relation to the Medicare population, with physicians' willingness to serve new Medicare beneficiaries essentially unchanged. Although the ratio of Medicare payment rates to private payment rates for physician services decreased slightly in 2002, it is still higher than in the mid-1990s, and the volume of physician services is increasing. Thus, the Commission recommends that payments for physician services be updated by the projected change in input prices, less an adjustment for productivity growth.

Skilled nursing facility services

The Commission concludes that Medicare payments for skilled nursing facility (SNF) services are more than adequate. Most beneficiaries appear to have sufficient access to SNF services, SNF capacity is stable, the volume of SNF services has been growing, and there are positive signs for SNFs' access to capital. The aggregate Medicare margin for freestanding SNFs is large enough to accommodate the projected increase in costs net of expected productivity improvements in 2005. Therefore, the Commission recommends that the Congress eliminate the update to payment rates for skilled nursing facility services for fiscal year 2005.

Although access to SNF services is good in general, some types of Medicare patients may experience delays in accessing care. This is because Medicare SNF payments are not fully aligned with the costs of caring for Medicare patients with different needs. Thus, we recommend that the Secretary develop a new classification system for care in skilled nursing facilities. Until this happens, the Congress should authorize the Secretary to reallocate the payment add-on currently applied to the rehabilitation payment groups to the nonrehabilitation payment groups so payments better follow patient costs. Furthermore, quality of care in nursing homes could be improved. We note that CMS is developing ways to measure and publically report the quality of care in this sector. As part

of those efforts, we recommend that the Secretary direct skilled nursing facilities to report nursing costs separately from routine costs.

Home health services

Medicare payments for home health services are more than adequate. Market factors show that access to care for most beneficiaries is good, quality has remained stable, and the number of agencies appears to have increased slightly in the past year. Our evidence suggests that improved productivity and product change will offset the increasing prices for home health inputs over the coming year; thus, the current margins, which are more than adequate, will persist. Therefore, the Commission recommends that the Congress eliminate the update to payment rates for home health services for 2005.

However, the payment system may make some types of beneficiaries less financially attractive than others, when ideally it should promote access to care for all types of eligible beneficiaries. We recommend that the Secretary continue to monitor access to care, the impact of the payment system on patient selection, and the use of services across post-acute settings. MedPAC will also continue work to determine whether refinements to the payment system are needed to improve access.

Outpatient dialysis services

Current Medicare payments for outpatient dialysis services are adequate. Our review of the evidence shows beneficiaries are not facing systematic problems in accessing care, the volume of services provided is increasing, providers have sufficient capacity to meet demand, quality is improving for some measures, and providers' access to capital is good. To account for changes in providers' costs in 2005, the Congress should maintain current law and update the composite rate for outpatient dialysis services by 1.6 percent—approximating the change in input costs less expected productivity gains.

Although quality has improved for some measures, current efforts have not improved care for all beneficiaries. Consequently, we recommend that the Congress establish a quality incentive payment policy for physicians and facilities providing outpatient dialysis services. By directly rewarding quality, the program will encourage investments in quality and improve the care beneficiaries receive.

Ambulatory surgical center services

We find that Medicare payments for ambulatory surgical center (ASC) services are at least adequate for 2004. Beneficiaries have good access to ambulatory surgical services. The supply of ASCs and the volume of ASC services received by Medicare beneficiaries have both increased significantly over the last several years. In addition, ASCs have sufficient access to capital. Current Medicare payments are at least adequate to cover the projected increase in ASCs' per-service costs in the coming year, less an adjustment for productivity growth. Therefore we recommend no update to payment rates for ASC services for fiscal year 2005.

We also recommend that the Secretary revise the ASC payment system so that its relative weights and procedure groups are aligned with those in the outpatient prospective payment system. The Congress should require the Secretary to periodically collect ASC cost data at the procedure level to refine the relative weights and to develop a conversion factor that reflects ASCs' costs. Medicare should pay no more for the same service in an ASC than an outpatient department (accounting for differences in the bundle of services).

Currently, CMS develops a list of procedures it will pay for in an ASC. After the ASC payment system is revised, we recommend that the Congress direct the Secretary to eliminate this list. Instead, CMS should pay for all ambulatory surgical procedures in an ASC except for those that do not meet clinical safety standards or that require an overnight stay. This will give physicians greater discretion over where to provide ambulatory surgical procedures and give beneficiaries wider choice, while ensuring that Medicare only pays for surgical procedures in ASCs when they are clinically appropriate for that setting.

Medicare+Choice payment policy

The Commission has consistently encouraged private plan participation in Medicare to provide beneficiaries a choice of delivery systems. Private plans have the flexibility to innovate and use management techniques such as coordination of care to potentially improve the efficiency and quality of health care services delivered to Medicare beneficiaries. The M+C program now provides the majority of Medicare beneficiaries a choice of delivery systems. The MMA created the Medicare Advantage program to replace and expand the M+C program, but many of the same issues currently facing the M+C

program will continue to pertain. In Chapter 4, we examine the current state of the M+C program, compare M+C payment with Medicare fee-for-service (FFS) spending, and make three recommendations.

First, to move toward financial neutrality between the FFS program and M+C plans we recommend that CMS continue to risk-adjust payments with the new risk adjustment system, but not continue to offset the impact of risk adjustment on overall payments. The Commission uses the concept of "financial neutrality" as a guiding principle for setting payment rates in the M+C program—the Medicare program should be financially neutral as to whether beneficiaries choose care under the FFS program or a private plan. If the program pays more than FFS costs to plans, they will have less financial pressure to improve the delivery of care. Second, to promote access for beneficiaries we recommend that the Congress allow beneficiaries with end-stage renal disease to enroll in private plans. Third, to reward improvements in quality for beneficiaries enrolled in private plans, we recommend that the Congress establish a quality incentive payment policy for all Medicare Advantage plans. ■